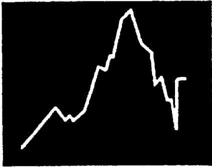

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

VIRGINIA BOARD OF HEALTH PROFESSIONS

REVIEW OF

DISCLOSURE OF DISCIPLINARY INFORMATION

ON HEALTH CARE PROVIDERS

IN THE COMMONWEALTH OF VIRGINIA

August 1996

OVERVIEW

The findings in this report were generated through a contracted study which was prompted by recent changes in law with regard to public access to disciplinary information on health care practitioners and a concomitant need to reevaluate disciplinary disclosure practices of the health regulatory boards operating within the Department of Health Professions (DHP)

Disciplinary information is described as any adverse information regarding a licensee which is in the possession of DHP. It includes, but is not limited to, allegations, citizen complaints, malpractice reports, investigations, notices of hearings, orders of health regulatory boards and other similar information.

For several years, law has limited public disclosure of disciplinary information by the Board of Medicine in the Commonwealth of Virginia. In recent years, the Boards of Dentistry and Psychology have sought and received identical confidentiality protection through the legislature and, currently, the Boards of Social Workers, Professional Counselors and Marriage and Family Therapists are seeking such protection. In effect, a member of the public seeking disciplinary information on health care practitioners licensed under the Boards of Medicine, Dentistry and Psychology can legally obtain far less information than is obtainable through other boards (e.g. Nursing, Pharmacy, Optometry) within the DHP. The trend toward more limited disclosure of disciplinary information as well as the inconsistencies across regulatory boards are appropriately evaluated in light of the following issues. First, DHP has an obligation to ensure public health and safety within the context of its duties and responsibilities. Second, public protection must be ensured without unnecessarily and/or unfairly damaging the reputations of health care practitioners. Third, the Board of Health Professions has an obligation to "review periodically the investigatory, disciplinary and enforcement processes of the Department and individual boards to ensure the protection of the public and the fair and equitable

treatment of health professionals." (Section 54.1-2510 of the Code of Virginia) Finally, there is an inherent obligation to provide sufficient means through which the public can evaluate the effectiveness and integrity of DHP's internal, disciplinary function.

While this study deals primarily with disclosure of disciplinary information and the type and amount of information necessary for members of the public to make informed decisions regarding health care practitioners, the issue of the disciplinary function is germane to discussion. Regardless of the type and amount of disciplinary information ultimately deemed appropriate for public consumption, the public's confidence in the processes that generate that information is at the heart of the issue.

With regard to disclosure of disciplinary information on health care practitioners, the following general questions were used in study development:

-What are the current policies and practices at DHP with regard to disclosure of disciplinary information and how can inconsistencies among boards within DHP be most effectively corrected? What type of information is most appropriately accessed by the public? Is complete information of a given type necessary or does summary information adequately address public health and safety needs.

- Do recent trends toward limited disclosure of disciplinary information by DHP, compromise public health and safety by providing too little information for informed decision making by members of the public (e.g. individuals, administrators of managed care programs, employers administering employee compensation programs and the like) ?

- What are the disclosure policies and practices in other states? For example, what type of information is publicly disclosed? Are there recent changes in the type and/or amount of disciplinary information that is disclosed? Through what means (e.g. automated phone system, written request etc.) does the public access information? Is there uniformity in policy across boards? Is public education provided with regard to access to disciplinary information?

- What are the public's concerns regarding disclosure of disciplinary information on health care practitioners?

- If information to the public is limited, how can public perceptions of adequacy and integrity of information be assured?

In exploring these questions, primary methods and sources include:

-literature review which includes related studies from other states and information provided by consumer groups;

-telephone and direct interviews with key individuals working with health regulatory boards and the investigations area of DHP;

-gathering and evaluation of information from boards in select states through mail questionnaires:

-public hearings and written responses to public hearing announcement;

-telephone interviews with representatives of consumer groups and members of the public who have expressed interest in the disclosure issue.

This report provides the substance of copious information. Due to dual and multiple applicability, some information is repeated in various sections of the text in order to adequately address issues. When practical, cumbersome information is placed in appendices so that the reader can seek additional information according to his or her desires.

EXECUTIVE SUMMARY

Disciplinary information on health care practitioners is made available to the public as a matter of assuring public health and safety. Such information is made available so that members of the public can make informed decisions with regard to the desirability and

safety of using the services of particular health care practitioners licensed in the Commonwealth of Virginia.

There is a trend in the Commonwealth toward limiting public disclosure of disciplinary information on health care practitioners through state law. Because such laws currently apply only to three boards (i.e. Medicine, Dentistry and Psychology) under the umbrella of Virginia's Department of Health Professions (DHP), inconsistencies exist across regulatory boards with regard to public disclosure of disciplinary information.

Policies and practices in other states selected for study are mixed. Recent trends, in other states, toward less disclosure are not identified in the study. However, there are apparent inconsistencies with regard to disclosure practices across boards within several states and there are identified cases of trends toward greater public education on disciplinary processes and access to information as well as greater public participation on boards.

Consumer concerns center around the need for sufficient information as well as a need for public confidence in disciplinary processes and decisions. Recent trends toward less disclosure of disciplinary information and inconsistency in disclosure practices across boards are considered in light of these issues.

The evaluation of findings in this study does not support reversing the trend toward limiting disclosure of disciplinary information. Eliminating inconsistencies across boards may be effectively accomplished through the more conservative policies used by the Boards of Medicine, Dentistry and Psychology. Nonetheless, in order to assure public health and safety and to maintain public confidence in systems that generate publicly available disciplinary information, limited disclosure practices should not be implemented in the absence of control mechanisms which would assure that: 1) content and quality of publicly available documents are sufficient for informed decision making on the part of consumers of health care services and 2) investigative and disciplinary processes are functioning in a manner which assures public health and safety while providing due

process to health care practitioners. In other words, monitoring of results generated by policies and processes must support assumptions of effectiveness.

DISCLOSURE OF DISCIPLINARY INFORMATION: AN EXAMINATION OF CURRENT PRACTICES AND CONCERNS

Examination of current policies and practices with regard to disclosure of disciplinary information is necessary in order to effectively explore existing inadequacies and inconsistencies and to find effective remedies which mitigate or eliminate such inadequacies and inconsistencies.

The Current Investigative and Disciplinary Process in Brief

(Information for this part of the study was collected from the investigative division of DHP as well as the following DHP boards: Dentistry, Funeral Directors, Medicine, Nursing, Optometry, Pharmacology, Psychology, Social Work.)

In Virginia, as in other states, it is often necessary to investigate instances of alleged misconduct on the part of health care practitioners who are licensed or otherwise credentialed in the Commonwealth. Evidence gathered during investigations may ultimately result in a sanction against a practitioner. These sanctions may range from a formal reprimand to revocation of credentials.

In Virginia, investigations of allegations of misconduct including consumer complaints are performed by an investigative body which serves all health regulatory boards. While the investigative function is performed by a division of DHP, that division operates independently from the boards and has no special allegiance to any particular board(s).

Prior to investigation, each complaint is evaluated by an intake officer who decides whether investigation is warranted. Provided an allegation is investigated, an investigative report will ultimately be provided to a committee of several members of a health

regulatory board which determines if evidence gathered during the investigation establishes probable cause for further action. If there is insufficient evidence, the case is closed. If evidence is sufficient, the practitioner against whom the allegation is made is provided notice of the allegation and the intent to proceed with an informal fact finding conference.

A practitioner facing an informal conference may acknowledge that allegations are true and appropriate findings and sanction will be applied through a consent order. If failure to reach a settlement occurs, a formal hearing will be held and a decision will be made. Sanctions, if determined appropriate, are described in an order which typically includes a finding of fact and conclusion of law. (See appendix A for examples of notices and orders.)

As a means of ensuring public health and safety, members of the public may request and receive from boards within DHP information generated by the disciplinary process. This study was prompted by known inconsistencies across boards with regard to disclosure of disciplinary information and an apparent trend in the Commonwealth toward limiting the information that may be publicly disclosed.

Information Disclosure: Inconsistencies across Boards. Prior to conclusion of investigation, information on an allegation is not publicly disclosed. However, beyond completion of investigations, inconsistencies exist across DHP boards with regard to disclosure. Inconsistencies of two primary types exist.

First, there is inconsistency among boards regarding the type of information that is publicly available. The law currently provides restricted access for information maintained by the Boards of Dentistry, Medicine and Psychology (restricted boards) with regard to confidentiality of <u>investigative</u> information. In effect, all information acquired by DHP during investigations is barred from public disclosure except in limited circumstances (see Appendix B.) Conversely, other boards (e.g. Funeral Directors, Nursing, Optometry, Pharmacy and Social Work) are not barred from disclosure of such information.

As a result, a member of the public seeking information on a practitioner licensed by a restricted board can essentially receive only that information included in notices of hearings and disciplinary orders. These include a summary description of the allegation and the ultimate outcome of the case (i.e. action taken or rationale for determining that a case be closed without action). On the other hand, a member of the public seeking information on a practitioner licensed by one of the other boards can technically receive all information gathered during the disciplinary process. (In the latter case, some exceptions exist because of DHP's use of exemptions under the Freedom of Information Act. Most notably, names of individuals are redacted from medical records.)

Second, restricted boards (i.e. Dentistry, Medicine and Psychology) provide information only on cases that reach the notice stage in the disciplinary process while others (e.g. Nursing and Optometry) provide information on cases that have been fully investigated. In the latter circumstance, members of the public seeking information on a health care practitioner may access information on allegations that were fully investigated but closed without further action because the investigation did not provide evidence sufficient to show probable cause. In the case of the restricted boards, existence of such cases is not publicly acknowledged.

In summary, restricted boards provide information only on allegations which are fully investigated and shown to have probable cause for further action. In effect, the threshold for disclosure exists at the point when a practitioner is formally informed through official notice of an allegation and the intention of the board to schedule an informal hearing. Notwithstanding the ultimate disposition of the case beyond that point, the notice and order are made publicly available.

Boards that are not required to restrict disclosure typically provide information on any allegation that has been fully investigated. Therefore, once an investigative report has been filed and the board has issued notice or closed the case due to lack of probable cause,

investigative information and any other materials related to the case become publicly available. (Again, medical records and other similar items are excluded.)

While inconsistencies in disclosure practices across boards do not necessarily indicate a lack of consistency in disciplinary processes among boards, such inconsistencies may adversely affect public perceptions of integrity of the disciplinary process. In addition, existing inconsistencies create inequity among various health care practitioners. In order to eliminate inconsistencies, evaluation of alternative disclosure practices must be made and a common method selected. Logically, initial evaluation must address recent trends toward more limited disclosure of disciplinary information.

Trends toward Limited Disclosure. DHP has an obligation to ensure public health and safety within the context of its duties and responsibilities. Sufficient information must be available in order for members of the public to make informed decisions regarding the safety and desirability of using the services of individual health care practitioners.

As indicated in the previous section, inconsistencies exist across boards at DHP with regard to disclosure of disciplinary information. In order to create a common policy across boards, current practices which limit disclosure must be eliminated so that an alternative approach can be adopted by or created for all boards <u>or</u> limited disclosure must be fully adopted by all boards within DHP.

The core issue is sufficiency. If limited information provided by restricted boards sufficiently addresses the public's health and safety needs, then that may be the solution to the problem of inconsistency. On the other hand, if limited disclosure does not adequately address the public's need, an alternative approach would be appropriate.

Responses from four primary sources were used in evaluating this question. First, individuals directing boards and others involved with disclosure within DHP were interviewed. Second, literature including related studies were reviewed. Third, impressions were gathered from consumer groups and various members of the public

through public hearings and telephone interviews. Finally, approaches to disclosure used in other states were explored.

DHP Response in Summary

The consensus within DHP is that more limited disclosure is adequate for informed decision making by individuals and others (e.g. administrators of managed care programs, employers managing employee compensation programs and the like) seeking information for the purpose of making informed decisions with regard to health care practitioners. In other words, such limitations provide sufficient information to the public without unnecessarily and unfairly damaging practitioners.

Primary concerns center around: 1) esoteric language typically used in notices and consent orders (i.e. manner of presentation) and 2) inconsistency across boards with regard to content in notices and consent orders. In addition, most interviewees regard notice as a more equitable threshold for disclosure than completion of investigation. This eliminates cases that are investigated and closed because probable cause for further action cannot be established from evidence gathered during the investigation. Assuming integrity of the investigative process, this threshold for disclosure is more fair to practitioners against whom unverifiable allegations are made.

In essence, if notices and consent orders include summary information presented in a manner that can be understood by members of the lay public, that information is generally considered sufficient to satisfaction of the public's need to make informed decisions regarding safety and desirability of using the services of individual practitioners. At the same time, this practice eliminates distribution of sensitive information such as medical records and the necessity of redacting names and other identifying information from files.

In addition, more limited disclosure and the use of notice as the threshold for disclosure on a particular disciplinary case is considered sufficient to satisfy public need while mitigating the possibility of unnecessarily damaging the reputations of practitioners.

Literature and Related Studies

Recent, relevant research regarding public disclosure of disciplinary information on health care practitioners concentrates primarily on: 1) type of disciplinary information provided (e.g. notices, orders, investigative information and the like) as well as the threshold for disclosure (e.g. complaints, pending cases etc.), 2) rates of discipline within jurisdictions, 3) ease of public access to disciplinary information and processes, 4) consumer education and consumer representation on regulatory boards, and 5) public disclosure of disciplinary actions and other board activities through press releases, newsletters, annual reports and the like.

In general, exploration of the type of information disclosed and the threshold for disclosure indicates that disclosed information typically includes documents comparable to DHP's notices and orders and that information is typically released on allegations following establishment of probable cause. Release of information on mere complaints or pending cases is rare.

While some reports generated by consumer groups argue that the threshold for disclosure should be lowered, there is little support for such action. Limited research indicates a correlation between complaints against practitioners and ultimate malpractice suits. However, no predictive relationship has been established.

Much discussion and exploration in the literature addresses integrity of disciplinary processes and related regulatory activities. Several approaches designed to positively enhance regulatory performance and public perceptions are commonly cited throughout literature. First, the importance of recording disciplinary rates and making them publicly

available is supported by evidence of low disciplinary rates by regulatory bodies. As an example, according to the Public Citizen Health Research Group, Virginia's State Board of Medicine ranked 32nd among states in 1994 with regard to "serious action taken" (i.e. licensure revocation, suspension, probation etc.) per 1000 medical doctors licensed by the Commonwealth. Serious actions taken per 1000 M.D.s was 3.76 percent. Key recommendations of this and similar reports support public disclosure of at least aggregate information on number and types of complaints received and the disposition of those complaints. The implication is that public confidence depends on evidence of integrity of processes as well as disciplinary information on individual practitioners and that self-reporting by regulatory agencies may mitigate public misperceptions.

Second, considerable emphasis is placed on ease of consumer access to information and to the complaint process. In general, literature suggests that summary disclosure of disciplinary information be made available over the phone either through an automated, 24 hour system or through direct contact with a board representative Similarly, over-the-phone acceptance of consumer complaints is encouraged as a means of enhancing consumer service.

Third, consumer education designed to create public awareness of the disciplinary process and other regulatory functions is recommended in the literature. For example, placement of informational brochures at pharmacies and practitioners' offices and other such efforts are commonly recommended. In addition, greater consumer representation on regulatory boards is recommended as a means of assuring integrity of disciplinary processes.

Finally, proactive, public disclosure of disciplinary actions is a commonly cited recommendation in the literature. While the public is typically informed of sanctions through regulatory board newsletters and annual reports, more aggressive use of mass media and more immediate public notification is recommended. In addition, news releases

pending cases raises questions of interference with investigations and due process. some states do provide information on the existence of pending cases without revealing details.

Additional expressed concerns of consumers and consumer representatives center more on integrity of systems generating disciplinary information than on the amount of information that can be obtained through public access. For example, there is concern that the rate of discipline in certain professions is low --- especially when compared with disciplinary rates of other boards. (Indeed, while the issue requires study beyond the scope of this report, there is some indication that such perceptions have at least limited support.)

Public skepticism of the processes generating information is notable in that it suggests a trade off between perceptions of processes and the amount of information desired by the public. In recent years, some states (e.g. Arizona) have addressed this issue through greater consumer representation on boards and various consumer education efforts.

Disclosure Practices of Select States

States included in the study are Arizona, California, Colorado, Florida, Georgia, Kentucky, Massachusetts, Maryland, North Carolina, Oregon, Tennessee, Texas, Utah, Vermont, Washington, and West Virginia. Boards included are Dentistry, Funeral Directors, Medical, Nursing, Optometry, Pharmacy, Psychology, and Social Work. States were chosen based on geography (i.e. border states), organization of boards (i.e. known similar organization to that of Virginia) and history of either general trend setting (i.e. Bellwether states) or known, recent exploration of this or related issues. Selected professions are those that are typically directly accessible by patients.

Surveys were sent to individual boards in all states except Colorado, Georgia, Massachusetts, Utah, Vermont, and Washington. The boards in these states are organized similarly to Virginia (i.e. the boards exist as a part of a larger entity such as DHP).

on other regulatory activities is cited as a means of enhancing performance and public perceptions of regulatory processes.

Consumer Response

Many members of the public may have an interest in obtaining disciplinary information on health care practitioners. Other sources of this study (e.g. interviews and surveys) reveal that the primary users of such information are individuals, employers (i.e. most typically potential employers of health care practitioners) and administrators of managed care programs such as Health Maintenance Organizations or Preferred Provider Organizations. Other commonly sited users are attorneys and representatives of insurance companies that provide malpractice insurance to health care practitioners.

Insight into consumer concerns were gained through public hearings and written responses (see appendix C), telephone interviews with individuals known to have an interest in the disclosure issue, and exploration of studies and other literature related to disclosure of disciplinary information.

Public hearings were held in Richmond and Roanoke on June 12, 1996 and June 13, 1996 respectively. In addition, written responses to notice of public hearings were received from: 1)) representatives of the Virginia Manufacturers Association, the Virginia Chamber of Commerce and the Virginia Hospital and Healthcare Association and 2) one health care practitioner, Joseph M. Doherty, DDS.

In general, the greater concern related to disclosure of disciplinary information is that of access to a full history of activity related to discipline on an individual practitioner. In other words, the amount of information regarding a given case is not as important as at least limited information on all incidences that warrant investigation including pending cases (i.e. cases currently being investigated.) While disclosure of information related to

Therefore, information on all eight boards was gathered through the umbrella agency. (One exception is Massachusetts. In that state the Medical Board is independent of the others.)

The survey includes questions related to the study and ancillary issues (see Appendix D). The response rate across boards was sixty-four percent with the greatest response rates from Boards of from Dentistry, Medicine, Nursing and Pharmacy.

The limited nature of this study with regard to numbers of states and boards surveyed restricts analysis and concrete findings. However, information gathered from respondents provides an overview of various practices throughout the United States with regard to disclosure of disciplinary information.

Notably, states operate in unique ways with no two states operating identically. In order to mitigate inaccuracies in responses due to differences in policy and terminology, a list of defined terms was provided for use in completing the survey. In addition, survey design was based, in part, on general information gathered from representatives of several boards throughout the United States so that commonalties and differences could be adequately accommodated. In order to further mitigate misunderstanding, space was provided for respondents to provide additional comments and explanation on any question.

Key questions on disclosure relate to: 1) the type and amount of information made publicly available, 2) procedures through which members of the public can access information and 3) procedures through which complaints against a health care practitioners are made. First, respondents were asked to indicate whether their board discloses information of the following types: disciplinary actions taken, pending cases, closed cases (i.e. cases that were investigated but did not result in discipline), and complaints.

Second, in order to determine the amount of information disclosed, respondents were asked to select from a range of possibilities with the least restrictive approach being that

all information is provided upon request and the most restrictive being that information is limited by law that specifically applies to the board's disclosure practices.

Third, in order to evaluate ease of public access to information, respondents were queried on procedures for accessing disciplinary information. Finally, procedures for making a complaint to a board against a health care practitioner were explored.

Type and Amount of Publicly Disclosed Information. Of the 82 respondents, 62 percent indicated that they provide information on disciplinary actions/sanctions only, 20 percent indicate that they provided information on disciplinary actions and closed cases. The remaining 18 percent indicate that they provide information on all categories included in the study. However, information on pending cases (i.e. cases under investigation), was typically limited to the mere existence of a complaint/allegation without further detail.

In response to the issue of the amount of information that is publicly disclosed, twenty-four respondents indicate that they provide all information (i.e. all information with names redacted and similar minor deletions), twenty-four indicate that all information is technically available but that discretion is used on a case-by-case basis, thirteen state that information is limited by policy, and eighteen indicate that statutory limits are placed on disclosure (i.e. statutory restrictions that limit the board's disclosure practices specifically.) Three respondents did not provide a clear response to the quire.

Those respondents providing comment on statutory restrictions typically indicate that investigative materials, patient records and consultant's notes could not be publicly disclosed. Similar comment was provided by some respondents who indicate that information disclosure is limited by board policy . In effect, where restrictions exist --- either through statute or policy decisions --- those restrictions primarily affect disclosure of investigative materials and similar items. Those respondents typically provide information from or copies of documents similar to notices and consent orders provided by the Medical, Dentistry and Psychology Boards at DHP.

No meaningful correlation exists between the type and amount of information provided by boards. Those boards which limit types of information (e.g. provide information on only disciplinary actions/sanctions) do not necessarily limit the amount of information that is provided. Conversely, those boards which provide many or all types of information (e.g. provide information on disciplinary actions, closed cases and complaints) do not necessarily publicly disclose investigative materials and other unofficial documents. In effect, limitation of information type does not necessarily coincide with limitation of the amount of information that is made publicly available. Due to inconsistent responses across states and boards within states, no meaningful observations can be made regarding degree of inconsistency across boards within other states. However, it is notable that inconsistencies across boards exist primarily in those states where boards are independent of one another. Those states with boards organized similarly to Virginia (i.e. boards existing under a common umbrella organization) do not report inconsistencies across boards.

Procedures for Public Access to Disciplinary Information. Most respondent boards (90 percent) indicate that disciplinary information on health care practitioners is accessible by phone. In most cases, a brief description of an allegation and any action taken is provided by phone and requests for additional information (i.e. copies of any available documentation) may be made by phone. In rare instances, a written request (i.e. either through a letter or completion of a specific form) for copied information is required. One respondent indicates that members of the public interested in seeing written information must review files at the board's offices.

Several boards (23 percent of respondents) either have or are in the process of implementing automated access to basic disciplinary information. One respondent board provides on-line access to basic disciplinary information.

Procedures for making Complaints. Most respondents report that individuals can make complaints regarding misconduct of health care practitioners over the telephone. (Indeed, most accept complaints from anonymous sources.) Others indicate that complaints must be made in writing or that complainants must complete specific forms.

SUMMARY AND RECOMMENDATIONS

Potentially legitimate allegations of misconduct against health care practitioners licensed or otherwise credentialed by the boards within the Department of Health Professions (DHP) must be investigated and appropriate discipline (e.g. reprimand, suspensions of license and the like) must be applied, if warranted.

DHP has a primary obligation to ensure public health and safety. Members of the public must have sufficient information if they are to make effective decisions regarding the safety and desirability of using the services of particular health care practitioners. Disclosure of disciplinary information (i.e. information generated by the investigative and disciplinary processes) on health care practitioners by the Department of Health Professions is an integral means of ensuring public health and safety.

In recent years, a trend toward more limited disclosure of disciplinary information has been generated by changes in law affecting some health regulatory boards. For many years, law has provided unique protection with regard to disclosure of disciplinary information to medical doctors. Recently laws have been passed which extend confidentiality to dentists and psychologists. The trend toward more limited disclosure of disciplinary information and resultant inconsistencies in disclosure practices across regulatory boards raises questions of efficacy of such practices in light of DHP's obligation to ensure public health and safety.

In an effort to determine the most effective and efficient approach to eliminating internal inconsistencies in disclosure practices at DHP, current practices in disclosure of disciplinary information in Virginia and other states were explored and consumer reaction

was sought through public hearings and interviews with representatives of consumer groups. In addition, recent related studies and other relevant literature were reviewed.

Broad Findings

* Inconsistencies with regard to disclosure of disciplinary information exist across boards within the Department Health Professions. Inconsistencies exist with regard to both type and amount of disciplinary information that is made publicly available.

* Similar inconsistencies exist across and within other states. However, information is typically released only on complaints which result in action beyond investigation and disciplinary actions.

* Primary concerns addressed by consumer groups include: 1) sufficient disclosure of disciplinary histories for purposes of informed decision making, 2) integrity of investigative and disciplinary processes from which practitioner information is derived, 3) ease of public access to information, and 4) public education on complaint and investigative processes and the like.

Recommendations

1) In order to eliminate inconsistency across health regulatory boards within DHP, a more limited approach to disclosure of disciplinary information is advised. First, information on allegations that result in notice should be made publicly available. The use of notice as the threshold for disclosure addresses the public's need for disciplinary information while eliminating disclosure on allegations that are investigated and closed without notice due to lack of probable cause for further action. Given that these allegations are not supported by investigative evidence, disclosure of these allegations may unnecessarily damage the reputation of a practitioner without contributing meaningfully to the public's needs.

As a caveat to this recommendation, it is strongly advised that records on cases that are closed following investigation due to lack of probable cause be retained and that they be placed into publicly available documents in the event that future and related cases result

in disciplinary action. In other words, previously inactionable cases which demonstrate a pattern of misconduct supporting a case in which probable cause exists should become a part of public record in the event of disciplinary action.

2) Investigative documents should be excluded from public disclosure and notices and orders should be made available. These documents, in combination, may provide information sufficient for informed decision making regarding the use of services of individual practitioners. However, quality control must be assured so that notices and orders consistently provide sufficient, clearly stated summary information on allegations and findings. At minimum, a statement fully describing the allegation, a summary of findings surrounding the allegation, action taken and rationale for action or inaction should be included in these documents.

3) A more limited disclosure policy can adequately address public need for information on health care practitioners provided integrity exists in investigative and disciplinary processes. In order to assure positive public perceptions, it is necessary that DHP establish means through which members of the public may evaluate performance of boards with respect to the disciplinary function. The centralized organizational structure of DHP and the member boards and the separation of investigative and disciplinary functions are conducive to this goal. (As a matter of efficiency and proficiency, it is advised that investigators work with cases involving a limited number of professions. However, no investigator should work exclusively with cases related to any one board.)

The ability of the public to evaluate performance of investigative and disciplinary functions may be enhanced through: 1) public education on the complaint process as well as the availability of disciplinary information and the means through which it can be accessed, and 2) creation of publicly available summary information on disciplinary rates. The latter should provide annual aggregate information for each board on number and types of allegations and the rate at which these allegations resulted in disciplinary action, closure after notice without disciplinary action and closure without notice (i.e. further

Study on Disclosure of Disciplinary Information

Summary of Recommendations based on Findings

Goal: To establish and maintain a disciplinary information disclosure system which effectively and efficiently satisfies public health and safety needs without unnecessarily and/or unfairly damaging the reputation of health care practitioners. The obligation to satisfy the public's need to access disciplinary information for the purpose of making truly informed decisions regarding the safety and desirability of using services of individual health care practitioners is paramount. However, this must be accomplished without wasting resources and without unnecessarily or unfairly damaging practitioners against whom unfounded or unverifiable allegations may be made.

Three broad requirements must be met. First, disclosure practices must be consistent across boards and disclosed information must be clearly presented and of an amount and type sufficient for decision making on the part average citizens. Second, the integrity of information sources (i.e. investigative and disciplinary processes) must be maintained. Finally, positive public perceptions of investigative and disciplinary processes must be assured.

Centralization of health regulatory boards under an umbrella agency such as DHP and separation of investigative and disciplinary processes contribute effectively to these requirements.

Findings in this study suggest that public faith in systems which generate information may mitigate need for elaborate disclosure practices. While evaluation of investigative and disciplinary functions is beyond the scope of this study, some recommendations are directed toward ensuring public confidence in these functions.

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Recommendations

-Disclose information on allegations that result in disciplinary action or which were closed following notice through informal or formal hearings

-Continue to omit disclosure of information related to allegations that are not deemed worthy of investigation or which are in the process of being investigated

-Across all boards, omit disclosure of information related to cases closed following full investigation and prior to notice. If investigation does not provide evidence sufficient to establish probable cause for further action, inclusion of such information may unnecessarily or unfairly jeopardize the reputations of health care practitioners without contributing meaningfully to public health and safety. (Exception/wavier should be provided if an affected practitioner officially requests such exception. In that event, information on existence and type of allegation as well as a brief summary of disposition and rationale for closure should be provided.)

-All disciplinary documents such as notices and orders should be made publicly available. Content must include: 1) type and summary of allegations and investigative findings, and 2) sanction applied and explanation of rationale for decision to take action or to close the a case without action. Information should be provided in lay terms either in the official documents or as a summary attachment to the documents.

Evaluation mechanisms should be established to assure consistency across boards with regard to content and disclosure of these documents. Records of quality control reviews should be publicly available.

-Develop a reporting system whereby each board must record and report, on an annual basis, aggregate information on the type and number of investigatable allegations as well as the disposition of those allegations (i.e. closed without notice, closed as result of informal or formal hearing or action taken). Reports should include organized presentation of rates of discipline for each category of allegation and a summary explanation of decisions.

As a means of assuring that the public's interests are satisfied through the investigative and disciplinary processes, official reports should be provided to the General Assembly and made publicly available through DHP and each of its boards upon request.

-Reestablish a system whereby disciplinary actions taken against health care practitioners by DHP boards are made publicly known. While publication in newsletters and the like may effectively inform the public, such approaches create more illusion than reality of public dissemination.

-Develop means through which the general public may become more familiar with the investigative and disciplinary processes within DHP. Public education issues should include means through which complaints can be made to DHP, types of allegations that are within the jurisdiction of DHP boards, brief descriptions of allegation types and available sanctions, means through which members of the public can obtain disciplinary information, type of information provided etc.

SELECTED REFERENCES

Selected Reports and Publications:

Bovbjerg and Petronis, "The Relationship between Physicians' Malpractice Claims History and Later Claims", JAMA 1994: 272.

"Exchange", The Federation of State Medical Boards of the United States. Inc.. Section 3: Licensing Boards, Structure and Disciplinary Functions, 1995-1996.

Making Informed Choices About Doctors: A Report by the Advisory Committee on Public Disclosure of Physician Information. The Secretary of Consumer Affairs and Business Regulation. Massachusetts Medical Society: April 1995.

Public Information Programs of State Boards of Nursing (Results of a Survey by the Citizen Advocacy Center), Citizen Advocacy Center, Washington, D.C.: 1991.

Public Representation on Health Regulatory, Governing and Oversight Bodies: Strategies for Success, Proceedings of a Workshop convened by The Citizen Advocacy Center, Washington, D.C.: December 1994.

Questionable Doctors: Disciplined by states or the federal government. State Listing for Virginia, A Public Citizen Health Research Group Report, Washington, D.C.: March 1996.

Release of Information to the Public by State Boards of Medicine and Nursing (Results of a Survey by the Citizen Advocacy Center), Citizen Advocacy Center, Washington, D.C.: April 1992.

Special Study: The Health Regulatory System. Report to the Arizona Legislature by the Auditor General (Report #95-13): December 1995.

Additional Sources:

Various reports generated by Virginia Department of Health Professions and its Boards (e.g. Report of Activities and Statistics, Board of Nursing; Department of Health Professions, Biennial Report, Department of Health Professions' Licensee Reports etc.)

Survey responses: selected states (i.e. border states, states known to have a similar organizational structure to that of DHP and other select states) and selected boards
Pubic Hearings and written commend submitted in response to public hearings
Telephone interviews with key individuals at other state's boards, representatives of consumer groups and others with interest in availability of disciplinary information (e.g. representatives of employer associations, members of the press etc.)

Interviews with board directors and other key individuals at Virginia's Department of Health Professions

Appendix A

The documents contained in this appendix are all public. The names of the individuals who are the subject thereof have been redacted as their identity is not relevant to this report.

COMMONWEALTH of VIRGINIA

Department of Health Professions

n W. Hasty
tor

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9900
FAX (804) 662-9943
TDD (804) 662-7197

September 20, 1995

CERTIFIED MAIL
Z 100 417 533

[redacted]S.
[redacted]
Richmond, Virginia 23235

Dear [redacted]

Enclosed please find a Consent Order from the Informal Conference Committee ("Committee") of the Board of Dentistry ("Board"), which met with you on September 8, 1995 in Henrico County, Virginia.

The Committee, upon consideration of the matters before it, has decided to offer you a Consent Order which will continue your license on probation with terms and conditions.

Please review the enclosed Consent Order carefully, should you agree to the terms of the Consent Order, have it signed before a notary public. In order for it to become effective, you must return this original Consent Order, bearing your witnessed signature, to the Board office within thirty (30) days. Upon receipt by this office, the Consent Order will be entered and a certified copy will be forwarded to you. Should we not receive this Consent Order from you within thirty (30) days, the Board will institute formal administrative proceedings to resolve this matter. Please be reminded that it is your responsibility to make sure that you fulfilled all terms of the Consent Order.

Should you have any questions regarding the Committee's recommendation, you may refer them to me or Pamela Horner, Administrative Assistant, at (804) 662-9906.

Sincerely,

Marcia J. Miller
Executive Director
Virginia Board of Dentistry

MJM:kcb.[redacted]

Enclosure

cc: James L. Banning, Director, Administrative Proceedings Division
Marvin A. Rosman, Esquire

VIRGINIA:

BEFORE THE BOARD OF DENTISTRY

IN RE: [redacted]

License No.: [redacted]

Complaint Nos.: 94-02046 & 95-00815

CONSENT ORDER

Pursuant to §§ 9-6.14:11 and 54.1-2400(8) of the Code of Virginia, an Informal Conference Committee ("Committee") of the Virginia Board of Dentistry ("Board"), composed of Robert J. Isaacson, D.D.S., M.S., Ph.D., and John S. Lyon, D.D.S., met with [redacted]., on September 8, 1995 in Henrico County, Virginia. [redacted] appeared in person and was represented by Marvin Rosman, Esquire. The purpose of the informal conference was to consider [redacted] compliance with the terms and conditions of the Consent Order entered October 11, 1993, and to receive and act upon evidence concerning the allegations in the Notice of Informal Conference dated August 9, 1995.

FINDINGS OF FACT

After consideration of the evidence and statements concerning the allegations, the Committee makes the following Findings of Fact:

1. [redacted], holds license number [redacted] issued by the Virginia Board of Dentistry.

2. By Consent Order entered October 11, 1993, [redacted] was placed on probation for substandard care and allowing unlicensed practice by dental assistants.

3. Between on or about March 7, 1991 and August 2, 1991, [redacted] provided dental treatment to Patient A. On or about April 3, 1991 [redacted] delivered a substandard crown on Patient A's tooth #19 in that the crown had an open margin on the distal. Subsequent to the

placement of the crown, failed to diagnose or treat the presence of the open margin causing recurrent decay on tooth #19.

4. Between on or about July 5, 1990 and February 17, 1993, provided dental treatment to Patient B. On or about July 23, 1990, he delivered a substandard bridge between Patient B's tooth #'s 14 and #16 in that the bridge was of poor construction resulting in the appliance separating on divers occasions, porcelain dislodging from the connector and a hole in the coping.

5. failed to ensure that each dentist, dental hygienist, assistant and technician employed or supervised by him certify in writing to the Board on a quarterly basis that each has read and understands the Board of Dentistry Regulations, in violation of Term #5 of the Consent Order entered October 11, 1993, in that he failed to include the certification by

CONCLUSIONS OF LAW

The Board concludes that Finding of Fact #3 through #5 constitute a violation of Term #5 of the Consent Order entered October 13, 1993, and § 54.1-2706(A)(5) and (10) of the Code of Virginia (1950), as amended, and § 4.3(4) of the Board of Dentistry Regulations.

CONSENT

by affixing his signature hereon, agrees to the following:

1. He has been advised specifically to seek the advice of counsel prior to signing this document;

2. He is fully aware that without his consent, no legal action can be taken against him except pursuant to the Virginia Administrative Process Act, § 9-6.14:1 <u>et seq</u> of the Code of Virginia;

3. He has the following rights, among others:

a. the right to a formal fact-finding hearing before the Board;

b. the right to representation by counsel; and

c. the right to cross-examine witnesses against him.

4. He waives all rights to a formal hearing;

5. He admits the truth of the above Findings of Fact; and

6. He consents to the following Order affecting his license to practice dentistry in the Commonwealth of Virginia.

ORDER

WHEREFORE, on the basis of the foregoing Findings of Fact, Conclusions of Law, and with the consent of the licensee, it is hereby ORDERED that , be, and hereby is continued on INDEFINITE PROBATION subject to the following terms and conditions:

1. The duration of the period of probation shall not be less than three (3) years. The Board specifically reserves the right to entertain any request for release from probation by Informal Conference, pursuant to § 9-6.14.11 of the Code of Virginia.

2. , shall be, and is hereby is, REPRIMANDED by the Virginia Board of Dentistry.

3. The TWO THOUSAND DOLLAR ($2,000.00) STAYED portion of the FIVE THOUSAND DOLLAR ($5,000.00) monetary penalty assessed against pursuant to the Consent Order entered October 11, 1993, shall be immediately LIFTED, and shall be paid to the Board within ten (10) days from the date of entry of this Consent Order.

4. shall be assessed a monetary penalty FIVE HUNDRED DOLLARS ($500.00) per finding of substandard care for a total assessed monetary penalty of ONE THOUSAND DOLLARS ($1,000.00), said penalty to be paid to the Board by certified check or money order within thirty (30) days from the date of entry of this Consent Order. If said monetary

penalty is not received within the prescribed deadline, an additional ONE HUNDRED DOLLAR ($100.00) late fee shall be assessed weekly, up to a maximum of ONE THOUSAND DOLLARS ($1000.00). Failure to pay the full monetary penalty plus the additional assessment within one hundred (100) days of the date of entry of this Consent Order shall constitute grounds for an administrative proceeding.

5. , shall be subject to annual, unannounced inspections of his dentistry practice by the Board or its designated representatives during the period of said probation. Each inspection shall include evaluations of five (5) randomly selected crown and bridge patient records, to include original pre-operative and post-operative x-rays and models. is solely responsible for the payment of a TWO HUNDRED DOLLAR ($200.00) inspection fee per inspection to be paid to the Board within thirty (30) days of each such inspection. If said fee is not received within the prescribed deadline, an additional ONE HUNDRED DOLLAR ($100.00) late fee shall be assessed weekly, up to a maximum of ONE THOUSAND DOLLARS ($1000.00). Failure to pay the full fee plus the additional assessment within one hundred (100) days of each inspection shall constitute grounds for an administrative proceeding. In the event that any such inspection reveals a possible violation of the laws or regulations pertaining to the practice of dentistry in Virginia, or Chapter 34 of Title 54.1, (§§ 54.1-3400 et seq) (Virginia Drug Control Act) of the Code of Virginia (1950), as amended, the Board specifically reserves the right to conduct further proceedings in this matter.

6. shall maintain a copy of the Board of Dentistry Regulations at his office, and shall have each dentist, dental hygienist, assistant and technician employed or supervised by him certify in writing to the Board on a quarterly basis that each has read

employed or supervised by him certify in writing to the Board on a quarterly basis that each has read and understands the regulations. These reports shall continue for three (3) years from the date of entry of this Consent Order, and shall contain the signatures of all staff members and [redacted] verifying the review.

7. [redacted]., shall conduct himself in accordance with the provisions of Chapter 27 of Title 54.1 of the Code of Virginia (1950), as amended, and the Regulations of the Virginia Board of Dentistry, and all laws of the Commonwealth.

Any violation of the foregoing terms and conditions of this Consent Order or any statute or regulation governing the practice of dentistry in the Commonwealth of Virginia shall constitute grounds for the suspension or revocation of the license of [redacted]., and an administrative proceeding shall be convened to determine whether [redacted] license to practice dentistry in the Commonwealth shall be suspended or revoked.

Pursuant to § 9-6.14:14 of the Code of Virginia, the signed original of this Consent Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public release, inspection and copying upon request.

FOR THE BOARD:

____

Patricia Lee Speer, D.D.S.
President

ENTERED: ____________________

SEEN AND AGREED TO:

____

COMMONWEALTH OF VIRGINIA

CITY/COUNTY OF ______________________

Subscribed and sworn to before me, a Notary Public in and for the city/county of ______________________, this ________ day of _________________, 1995, by .

____

Notary Public

My Commission Expires: _____________

RECEIVED: ___________________________________

BY: _____________________________________

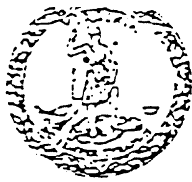
John W. Hasty, Director
Department of Health Professions

Certificate of Service

I hereby certify that a true copy of the foregoing Consent Order was mailed to Virginia 23235, on the ________ day of _______________, 1995.

____

Marcia J. Miller
Executive Director
Board of Dentistry



COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Dentistry

arcia J. Miller
ecutive Director of the Board

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9906
FAX (804) 662-9943
TDD (804) 662-7197

June 27, 1995

CERTIFIED MAIL
Z 100 410 368

[redacted]
Richmond, Virginia 23235

RE: NOTICE OF INFORMAL CONFERENCE
Complaint No. 94-02046\95-00815

Dear [redacted]

This is an official notification that an informal conference will be held on Friday, July 28, 1995, at the Department of Health Professions, 6606 West Broad Street, Richmond, Virginia 23230. You are directed to appear at 2:30 p.m. and sign in at the Fourth Floor reception area upon arrival.

The conference will be conducted pursuant to §§ 54.1-110 and 9-6.14:11 of the Code of Virginia (1950), as amended.

An informal conference committee ("Committee"), which is composed of three members of the Virginia Board of Dentistry, will receive and act upon evidence that you may have violated laws governing the practice of dentistry in the Commonwealth of Virginia and consider your compliance with the terms and conditions of probation placed on your license by Consent Order entered October 11, 1993. Specifically, you may have violated § 54.1-2706(A)(5) and (10) of the Code of Virginia (1950), as amended, and § 4.3(4) of the Board of Dentistry Regulations, in that:

1. By Consent Order entered October 11, 1993, [redacted] was placed on probation for substandard care and allowing unlicensed practice by dental assistants.

2. Between on or about March 7, 1991 and August 2, 1991, you provided dental treatment to Patient A. On or about April 3, 1991, you delivered a substandard crown on Patient A's tooth #19 in that the crown had an open margin on the distal. Subsequent to the placement of the crown, you failed to diagnose or treat the presence of the open margin causing recurrent decay on tooth #19.

icia Lee Speer, D.D.S. President | Alonzo M. Bell, D.D.S. Vice-President | Catherine C. Haywood, R.D.H., M.Ed. Secretary-Treasurer | Mark A. Crabtree, D.D.S. Martinsville | Paul F. Ferguson, Esquire Arlington

3. Between on or about July 5, 1990 and February 17, 1993, you provided dental treatment to Patient B. On or about July 23, 1990, you delivered a substandard bridge between Patient B's tooth #'s 14 and #16 in that the bridge was of poor construction resulting in the appliance separating on divers occasions, porcelain dislodging from the connector and a hole in the coping.

You may be represented by an attorney at the informal conference. After reviewing the investigative report(s) and the alleged violation(s) with you, the informal conference committee will make a recommendation of appropriate action. If the Committee is of the opinion that the charges are without foundation you will be notified that you record has been cleared of any charge which might affect your right to practice dentistry in the Commonwealth.

If the Committee is of the opinion that dismissal of the charges is not appropriate, the Committee shall either:

1. With your consent, present the Committee's findings and conclusion in writing to the full Board with the recommendation for disciplinary sanction, or

2. Refer the case for a formal hearing in accordance with §§54.1-110, 54.1-2708 and 9-6.14:12 of the Code of Virginia (1950), as amended.

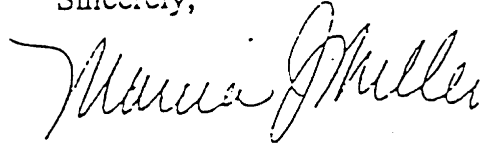
<u>Should you fail to appear at the informal conference, the Board may proceed to a formal administrative hearing in order to impose sanctions which could result in a suspension or revocation of your license, as well as the imposition of monetary penalties. Please inform this office of your intention to appear at the conference at least fifteen (15) days prior to the scheduled date above</u>. Also, please provide the Board a telephone number where you may be reached.

If you have any additional documents to be presented to the Conference Committee, please bring five (5) copies of each document with you.

You have the right to a copy of the investigative report and supporting documents that me be used as evidence at your informal conference. These documents are enclosed with the notice of informal conference sent to you by certified mail, and are available for your pick-up at the post office. Also, copies of the relevant sections of the Administrative Process Act, which govern proceedings of this nature, as well as the laws and regulations relating to the practice of dentistry in Virginia.

When this matter is closed, all documents in this case become public documents under the Freedom of Information Act.

Sincerely,



Marcia J. Miller
Executive Director
Virginia Board of Dentistry

MJM/kcb [redacted]

Enclosure

cc: Members, Informal Conference Committee
John W. Hasty, Director, Department of Health Professions
James Banning, Director for Administrative Proceedings
Division of Enforcement (91-00255\91-00665)
Reneè Dixson, Probation and Enforcement Planning

COMMONWEALTH of VIRGINIA

Department of Health Professions

Board of Dentistry

:a J. Miller
:ive Director of the Board

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9906
FAX (804) 662-9943
TDD (804) 662-7197

March 26, 1996

CERTIFIED MAIL
Z 100 418 588

Richmond, Virginia 23235

RE: Notice of Formal Hearing
May 9, 1996 at 10:30 a.m.

Dear

Enclosed please find a Notice of Hearing which is scheduled for May 9, 1996 at 11:00 a.m. at the Department of Health Professions, 6606 West Broad Street, 4th Floor, Richmond, Virginia. Arrangements should be made for you to be there at 10:00 a.m.

You have the right to have a copy of the investigative report and supporting documents which may be used as evidence at your hearing. Please be advised that these documents have been forwarded to you under same cover via certified mail. Your counsel, Darren Hart, Esquire, has also been provided with the same.

Prior to the hearing, it is the Board's intention to distribute these documents to the members of the Board who will conduct the hearing. If you have any objections to the materials, please contact Mary Beth Shelton, Senior Legal Assistant at (804) 662-7084 before April 19, 1996. If you do not object to this proposed distribution before April 19, 1996, the Board will assume that you have no objection to the Board member's prior review of the documents. Failure to object to the distribution prior to the hearing will not affect your right to contest any information contained in these documents at the hearing.

If you should have any questions, please contact us at the above number.

Sincerely,

Marcia J. Miller
Executive Director

:ncia Lee Speer, D.D.S. President Chesapeake | Robert J. Isaacson, D.D.S., M.S., Ph.D. Vice-President Richmond | French H. Moore, Jr., D.D.S. Secretary-Treasurer Abingdon | Alonzo M. Bell, D.D.S. Alexandria | Mark A. Crabtree, D.D.S. Martinsville

MJM/kcb [redacted]

Enclosures

cc: John W. Hasty, Director, Department of Health Professions
Frank W. Pedrotty, Assistant Attorney General
Darren Hart, Esquire (w/ enc.)
Shevaun Roukous, Office of the Attorney General
Division of Enforcement (94-02046/95-00815)
Reneè Dixson, Probation & Enforcement Planning

VIRGINIA:

BEFORE THE BOARD OF DENTISTRY

IN RE: [redacted]
License No. [redacted]

NOTICE OF HEARING

Pursuant to § 9-6.14:12 and § 54.1-110 of the Code of Virginia (1950), as amended ("Code"), you are given notice that in accordance with § 9-6.14:14.1(F) and § 54.1-2400(9), a hearing will be held before a panel of the Board of Dentistry ("Board"). The hearing will be held on May 9, 1996, at 10:30 a.m. at the Department of Health Professions, 6606 West Broad Street, Conference Room 2, Richmond, Virginia, at which time you will be afforded the opportunity to be heard in person or by counsel.

At the hearing, you have the following rights among others: the right to representation by counsel, the right to have witnesses subpoenaed and to present witnesses on your behalf, the right to present documentary evidence, and the right to cross-examine adverse witnesses. If you desire any witnesses to appear on your behalf, notify the Executive Director of the Board of Dentistry, 6606 West Broad Street, Suite 400, Richmond, Virginia 23230-1717, giving the names and addresses of the witnesses, at least fifteen (15) days prior to the date of the hearing in order that subpoenas may be issued.

The purpose of the hearing is to receive and act upon evidence that you may have violated certain laws and regulations governing the practice of dentistry in the Commonwealth of Virginia, as more fully set forth in the Statement of Particulars below.

STATEMENT OF PARTICULARS

The Board alleges that [redacted], has violated § 54.1-2706(A)(5) and (10) of the Code of Virginia (1950), as amended, and § 4.3(4) of the Board of Dentistry Regulations, and Term #5 of the Consent Order entered October 11, 1993, in that:

1. By Consent Order entered October 11, 1993, [redacted] was placed on probation for substandard care and allowing unlicensed practice by dental assistants. [redacted] failed to have each dentist, dental hygienist, assistant and technician employed or supervised by him certify in writing that each has read and understands the Board of Dentistry Regulations as maintained in [redacted] office, as required by Term #5.

2. Between on or about March 7, 1991 and August 2, 1991 [redacted] provided dental treatment to Patient A. [redacted] initiated treatment, performed all crown prep work and provided follow-up care to Patient A after the placement of a crown on Tooth #19. On or about April 13, 1991, [redacted] failed to diagnose or treat the presence of an open margin on the distal which caused recurrent decay of Tooth #19.

3. Between on or about July 5, 1990 and February 17, 1993, [redacted] provided dental treatment to Patient B. On or about July 23, 1990 [redacted] delivered a substandard bridge on Patient B's tooth #'s 14 and #16 in that the bridge was of poor construction resulting in the appliance separating on divers occasions, porcelain dislodging from the connector and a hole in the coping.

FOR THE BOARD

Marcia J. Miller
Executive Director

Entered: March 25, 1996

COMMONWEALTH of VIRGINIA

Department of Health Professions
Board of Dentistry

rcia J. Miller
cutive Director of the Board

6606 West Broad Street, Fourth Floor
Richmond, Virginia 23230-1717
(804) 662-9906
FAX (804) 662-9943
TDD (804) 662-7197

June 4, 1996

CERTIFIED MAIL
Z 356 169 964

Richmond, VA 23235

Dear Dr.

Enclosed is a Copy Teste of the Board's Order dated May 10, 1996, continuing your license to practice dentistry in Virginia on Probation with terms and conditions.

Please note that the responsibility for completing the terms of the Consent Order, lies solely with you (ex.: payment of fees, quarterly reports and maintaining records).

Should you have any questions regarding this matter, please contact the Board office.

Sincerely,

Marcia J. Miller
Executive Director
Virginia Board of Dentistry

/ph

Enclosure

cc: Members, Board of Dentistry
Renee Dixson, Probation Analyst
Complainant(s)
Administrative Proceedings

Patricia Lee Speer, D.D.S. President | Robert J. Isaacson, D.D.S., M.S., Ph.D. Vice-President | French H. Moore, Jr., D.D.S. Secretary-Treasurer | Alonzo M. Bell, D.D.S. Alexandria | Mark A. Crabtree, D.D.S. Martinsville

VIRGINIA:

BEFORE THE BOARD OF DENTISTRY

IN RE: [redacted]
License No. 0401-006421

ORDER

Pursuant to §§ 9-6.14:12, 54.1-110 and 54.1-2400(9) of the Code of Virginia (1950), as amended, a formal administrative hearing of the Virginia Board of Dentistry (hereinafter, the "Board"), composed of a panel of the members of the Board was held on May 9, 1996, in Henrico County, Virginia. The case was presented by Frank W. Pedrotty, Assistant Attorney General. Howard M. Casway, Assistant Attorney General, was present as Board counsel. [redacted], was present and was represented by Marvin Alan Rosman, Esquire. The purpose of the formal hearing was to receive and act upon evidence concerning the allegations in the Notice of Hearing and Statement of Particulars dated March 26, 1996.

FINDINGS OF FACT

After consideration of the evidence presented, the Board made the following Findings of Fact:

1. [redacted] holds License No. 0401-006421 issued by the Board to practice dentistry in Virginia.

2. By Consent Order entered October 11, 1993, [redacted] was placed on probation for substandard care and allowing unlicensed practice by dental assistants.

3. Between on or about March 7, 1991 and August 2, 1991, [redacted] provided dental treatment to Patient A. [redacted] initiated treatment, performed all crown prep work and provided follow-up care to Patient A after the placement of a crown on Tooth #19. On or

about April 3, 1991, [redacted] failed to diagnose or treat the presence of an open margin on the distal which caused recurrent decay of Tooth #19. [redacted] further failed to advise the patient that the crown was defective and should have been replaced as exemplified by the immediate post-operative radiograph.

CONCLUSIONS OF LAW

The Board concludes that Finding of Fact #2 constitutes a violation of § 54.1-2706(A)(5) of the Code of Virginia (1950), as amended, and § 4.3(4) of the Board of Dentistry Regulations.

ORDER

WHEREFORE, on the basis of the foregoing Finding of Fact and Conclusion of Law, it is hereby ordered that [redacted] be and hereby is CONTINUED on PROBATION subject to the following terms and conditions:

1. The period of probation shall begin on the date that this Order is entered and shall continue INDEFINITELY. [redacted] may petition the Board to end his probation after not less than two (2) years from the date of entry of this Order.

2. [redacted] shall be subject to annual, unannounced inspections of his practice by the Board or its designated representatives during the probation period. Each inspection may include randomly selected patient records and on-site observations of his treatment of patients. [redacted] solely responsible for the payment of a two hundred ($200.00) inspection fee to be paid to the Board within thirty (30) days of each such inspection. If said fee is not received within the prescribed deadline, an additional one hundred dollar ($100.00) late fee shall be assessed weekly, up to a maximum of one thousand dollars ($1000.00). Failure to pay the full

fee plus the additional assessment within one hundred (100) days of each inspection shall constitute grounds for an administrative proceeding. In the event that any such inspection reveals a possible violation of the laws or regulations pertaining to the practice of dentistry in Virginia, or Chapter 34 of Title 54.1, (§§ 54.1-3400 et seq)(Virginia Drug Control Act) of the Code of Virginia (1950), as amended, the Board specifically reserves the right to conduct further proceedings in this matter.

3. [redacted] shall be assessed a monetary penalty of one thousand dollars ($1000.00), said penalty to be paid to the Board by certified check or money order within thirty (30) days from the entry of this Order. If said monetary penalty is not received within the prescribed deadline, an additional one hundred dollar ($100.00) late fee shall be assessed weekly, up to a maximum of one thousand dollars ($1000.00). Failure to pay the full monetary penalty plus the additional assessment within one hundred (100) days of this Order shall constitute grounds for a formal administrative hearing.

4. The two thousand dollar ($2000.00) monetary penalty imposed and stayed by the Consent Order entered by the Board on October 11, 1993, shall remain STAYED and shall not be assessed against [redacted] unless he is determined to be in violation of the terms of this Order and shall be finally dismissed and no longer subject to assessment upon [redacted] successful completion of probation. Should the Board or a panel thereof determine that [redacted] violated any of the terms of this Order or any of the statutes or regulations governing the practice of dentistry in Virginia, such determination shall constitute grounds for the immediate recision of the stay of the monetary penalty and the two thousand dollar

($2000.00) monetary penalty shall be paid to the Board within ten (10) days of such action by the Board.

5. [redacted] shall maintain a copy of the Board of Dentistry Regulations at his office, and shall have each dentist, dental hygienist, assistant and technician employed or supervised by him, or practicing as an independent contractor in a facility owned by him, certify in writing to the Board on a quarterly basis that each has read and understands the regulations. These reports shall continue for two (2) years from the date of entry of this Order and shall contain the signatures of all staff members and [redacted] verifying the review.

6. [redacted] shall successfully complete within one (1) year from the date of entry of this Order, twenty-five (25) hours of Board-approved remedial education in fixed prosthetics. [redacted] shall receive approval from the Board prior to enrolling in any program of study. All arrangements, including expenses for the course shall be the responsibility of [redacted], and [redacted] shall present satisfactory evidence of completion of this program of study to the Board.

7. [redacted] shall conduct himself in accordance with the provisions of Chapter 27 of Title 54.1 of the Code of Virginia (1950), as amended, and the Regulations of the Virginia Board of Dentistry, and all laws of the Commonwealth.

Any violation of the foregoing terms and conditions of this Order or any statute or regulation governing the practice of dentistry in the Commonwealth of Virginia shall constitute grounds for the suspension or revocation of the license of [redacted]., and an administrative proceeding shall be convened to determine whether [redacted] license to

practice dentistry in the Commonwealth shall be suspended or revoked.

Pursuant to § 9-6.14:14 of the Code of Virginia (1950), as amended, the signed original of the ORDER shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public release, inspection and copying upon request.

As provided by Rule 2A:2 of the Supreme Court of Virginia, [redacted]., has thirty (30) days from the date of service (the date he actually received this decision or the date it was mailed to him, whichever occurred first) within which to appeal this decision by filing a Notice of Appeal with Marcia J. Miller, Executive Director, Virginia Board of Dentistry. In the event that this decision is served on him by mail, three days are added to that period.

FOR THE BOARD:

Patricia L. Speer, D.D.S., President

ENTERED: 5-10-96

RECEIVED: May 20 1996

BY:

John W. Hasty, Director
Department of Health Professions

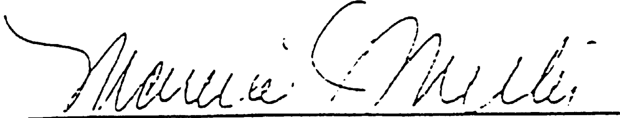
Certificate of Service

I hereby certify that a true copy of the foregoing order was mailed to [redacted] on the 4th of June, 1996.

Marcia J. Miller
Executive Director
Board of Dentistry

RE: [redacted]

TRUE COPY TESTE



Marcia J. Miller
Executive Director
Virginia Board of Dentistry

June 3, 1996
DATE

APPENDIX B

913 Professions and occupations; confidentiality of information.

725352

HOUSE BILL NO. 1913
Offered January 20, 1995

ILL to amend the Code of Virginia by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.1, relating to confidentiality of investigative information; penalty.

Patron--Melvin

Referred to Committee on General Laws

Be it enacted by the General Assembly of Virginia:
That the Code of Virginia is amended by adding in Article 1 of Chapter 27 of Title a section numbered 54.1-2708.1 as follows:
§ 54.1-2708.1. Confidentiality of investigative information required; penalty.
A. Any reports, information or records received and maintained by the Board in nection with possible disciplinary proceedings, including any material received or eloped by the Board during an investigation or hearing, shall be strictly confidential. ever, the Board may only disclose any such confidential information:
1. In a disciplinary hearing before the Board or in any subsequent trial or appeal of a rd action or order;
2. To licensing authorities located outside this Commonwealth which are concerned granting, limiting or denying a dentist a license to practice if a final determination rding a violation of this chapter has been made;
3. Pursuant to an order of a court of competent jurisdiction; or
4. To qualified personnel for bona fide research or educational purposes, if onally identifiable information relating to any patient or dentist is first deleted and a l determination regarding a violation of this chapter has been made.
B. Orders of the Board relating to disciplinary action against a dentist are not iired to be confidential.
C. In no event shall confidential information received, maintained or developed by Board, or disclosed by the Board to others, pursuant to this section, be available for overy or court subpoena or introduced into evidence in any medical malpractice suit ther action for damages arising out of the provision of or failure to provide services. ever, this section shall not be construed to inhibit an investigation or prosecution er Article 1 (§ 18.2-247 et seq.) of Chapter 7 of Title 18.2.
D. Any person found guilty of the unlawful disclosure of such confidential rmation possessed by the Board shall be guilty of a Class 1 misdemeanor.
E. Any claim of physician-patient privilege shall not prevail in any investigation or eeding by the Board acting within the scope of its authority. However, the losure of any information pursuant to this provision shall not be deemed a waiver of 1 privilege in any other proceeding.
F. This section shall not prohibit the Director of the Department of Health essions, after consultation with the Board president or his designee, from disclosing

APPENDIX C

DIRECTOR'S OFFICE JUN 1 0

June 3, 1996

Department of Health Professions
Board of Health Professions
6606 West Broad Street
Richmond, VA 23230

Re: Public Hearing : Disclosure of Disciplinary Information

Let me first state that I appreciate the difficult task that the Boards face in carrying out their obligation to protect the public. It is a difficult job and the members on the Boards are to be complimented for their willingness to serve.

In your announcement regarding this hearing you noted that the "law restricts the disclosure of all but formal information for some professions (physicians , dentists and psychologists) while permitting or mandating the disclosure for others (nurses, pharmacists and counselors)". Unfortunately you gave no examples of what those additional disclosures might be for the second group thereby making it difficult to comment on what is being proposed.

While I think it is the responsibility of the Board to protect the public, it must at the same time not jeopardize the practitioner by the release of unsubstantiated charges. It would seem the present system of publishing the results in the individual Board newsletter is adequate. I assume that information is available to the public. Care must be taken to avoid the implication that any charge for which the practitioner may be found guilty is equal in its consequences to the public. For example, a practitioner found guilty of improper sexual advances to a patient is not the same as letting a dental assistant expose radiographs without having taken the Board examination.

Unless there is information of which I am not aware, I think the present system for the dentists seems to be working for the protection of the public and it may not be necessary to change that . To have uniformity of disclosure for all patients may not necessarily be the be the most desirable, but rather the relation of the patient to the profession and its consequences ought to be the deciding factor.

Thank you for the opportunity to comment.

Sincerely,

Joseph M. Doherty

Joseph M. Doherty, DDS, MPH
10619 Jousting lane
Richmond, VA 23235-3838
804-272-8344

The Virginia Chamber of Commerce
9 South Fifth Street / Richmond, Virginia 23219-3890 / (804) 644-1607 / (804) 783-6112 (FAX)

June 11, 1996

Mr. John W. Hasty
Director
Department of Health Professions
6606 West Broad Street
Richmond, VA 23230-1717

Dear Mr. Hasty:

We understand that the Board of Health Professions has scheduled public hearings in Richmond and Roanoke on June 12 and June 13, respectively, to receive comments from the public on the disclosure of disciplinary information concerning health care providers under the purview of your agency and its regulatory boards.

I regret that the Virginia Chamber of Commerce cannot be represented at either meeting. I am enclosing, however, comments which I trust will be submitted to the board and made part of its record.

The Virginia Chamber and its members are vitally interested in the availability of information about health care professionals which will equip purchasers and consumers to make better and more informed health care choices. Please do not hesitate to let us know if we can assist this study in any way.

Sincerely,

Sandra D. Bowen
Senior Vice President

SDB:cgf

Enclosure

The Virginia Chamber of Commerce

9 South Fifth Street / Richmond, Virginia 23219-3890 / (804) 644-1607 / (804) 783-6112 (FAX)

COMMENTS OF THE VIRGINIA CHAMBER OF COMMERCE ON THE DISCLOSURE OF DISCIPLINARY INFORMATION

SUBMITTED TO THE VIRGINIA BOARD OF HEALTH PROFESSIONS

June 11, 1996

The Virginia Chamber of Commerce is appreciative of the opportunity to provide comment on the disclosure of disciplinary information concerning physicians, nurses, dentists, psychologists, and other health practioners under the authority of the Virginia Department of Health Professions.

The Virginia Chamber of Commerce represents large and small businesses in every economic sector from every region of the Commonwealth. Our membership also includes local chambers of commerce and business and trade associations. Simply put, our members are major purchasers of health care and, as such, have an interest in the quality, affordability, and accessibility of health care for themselves, their employees, and their families.

In recent years, we have advocated generally for the provision of meaningful and useful information from all components of the health care "system" which will equip purchasers, consumers, and even policy-makers to make good health care decisions. Specifically, we supported data initiatives under the Health Services Cost Review Council, the establishment of Virginia Health Information, Inc. (VHI), and, more recently, HB 1307 (1996) which places responsibility with VHI for certain data projects and directs it to develop a strategic plan for other data initiatives by October of 1996.

The Virginia Chamber also supported HB 1194 (1996) which requires practioners who have been disciplined by the Board of Medicine to notify their patients, any hospitals with which they have privileges, and health plans which re-imburse them for services of any suspension or revocation of licenses. This measure did not seem to us to be punitive. Rather, it is a reasonable requirement, not unlike that made of other professionals.

There is ample research as well as anecdotal evidence that purchasers of health care and individual consumers want more information but are uncertain as to how to obtain it. They are asked to make important choices about health plans and health providers with little definitive information to instruct those choices. We can tell you in no uncertain terms that small and middle-sized businesses especially want more information that is understandable and meaningful. Because we strongly support market-driven health care delivery, we strongly support improved information about the quality and cost of the services of providers and insurers.

The Virginia Board of Health Professions and the regulatory boards which you oversee can, in conjunction with the activities of VHI, make an enormous contribution to this end. The Virginia Chamber of Commerce is prepared to assist in your efforts as may be appropriate and we salute your foresight in conducting this study. We hope we can assist you in keeping faith with the public trust vested in your boards.

Submitted by Sandra D. Bowen, Senior Vice President

The Voice of Business in Virginia

RGINIA MANUFACTURERS ASSOCIATION
Box 412, Richmond Virginia 23218-0412, 804/643-7489, FAX 804/780-3853

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. GORDON WILLIS, JR., Culpeper
Culpeper Stone Company, Inc.
STEVE WITTIG, Lebanon
Automotive Industries
Denotes Executive Committee
CAROL C. WAMPLER
Vice President & General Counsel

June 3, 1996

Board of Health Professions
Department of Health Professions
6606 W. Broad Street
Richmond, VA 23230

Dear Ladies and Gentlemen:

The Board of Health Professions has published a notice for two public hearings, June 12 (Richmond), and June 13 (Roanoke), as part of a review of the disclosure of disciplinary information in the possession of the health regulatory boards. Because I will be unable to appear in person at either of those hearings, I am submitting these comments in writing, and request that they be considered as part of that review. I also request that the Virginia Manufacturers Association be added to your list of interested organizations in order that we might receive future notices and information.

The Virginia Manufacturers Association represents over 500 manufacturing companies in Virginia. Its member companies employ approximately 90% of the manufacturing workforce. Almost all of these companies provide health care or health insurance to their employees. In many companies, the employees also contribute toward the premium cost, especially for family coverage. In short, these employers and employees are purchasers and consumers of health care.

As acknowledged in the notice of the public hearing, the purpose of professional regulation is to help assure the safe delivery of care. Some disciplinary information may also be relevant in assessing the quality of care. Examples include assessing the network of participating providers offered by a health care or insurance company, or the choice of a personal physician or dentist. "Disciplinary information," as described in the notice, includes everything from uninvestigated complaints to orders imposing sanctions. It may be useful to work backwards through the list.

Orders imposing sanctions should include a written finding of misconduct, and should be disclosed when they are final orders. If the process was initiated by a complaint, the complainant should be notified by the appropriate board. Moreover, the licensee should be required, in the order, to notify patients with whom he or she has an ongoing professional relationship, any hospitals, clinics or health care providers affording him or her practice privileges, any entity employing him or her to furnish licensed services, and any health care plan or insurance company currently reimbursing him or her for licensed services. The order should be a public record available under the Virginia Freedom of Information Act. For particularly egregious cases, perhaps those resulting in revocation of the license, the Department or board should be authorized to disseminate the final order to the media.

Today, judgments regarding the quality of a provider rely primarily upon academic background, professional certification, and word of mouth. Disciplinary history, if any, is equally relevant, and public policy clearly should favor the availability of this information to purchasers and consumers when the process has run its course.

Notices of fact-finding proceedings containing specific charges of misconduct are, at this stage, allegations. No finding has been made, although the complaint survived the initial screening, and, in some cases, some preliminary investigation. Under these circumstances, the strong public policies reflected in the Administrative Process Act and the Virginia Freedom of Information Act outweigh the potential damage to reputation. The notices should be subject to disclosure, but without the affirmative duty to disseminate described above, except to the complainant, if any.

Reports of investigation prepared by the Department should not be disclosed. If a basis exists for disciplinary action, the matter should be referred to the appropriate committee or board, where the evidence will be properly evaluated. If the investigation developed insufficient material to justify disciplinary action, the complainant, if any, and the subject should be so advised.

Reports from health care entities regarding providers is a broad category. Clearly, items that are already a matter of public record, such as disciplinary actions in other jurisdictions, criminal convictions, and malpractice judgments or settlements ought not to be secreted simply because they have been gathered by the Department. The public policy endorsed above should encourage their availability. At the same time, required reports include, for example, evidence that a licensee is or may be professionally incompetent, guilty of unprofessional conduct or mentally or physically unable to engage safely in the practice of the profession. These are "raw" opinions, untested and unchallenged, and while they might trigger further investigation leading to disciplinary action, disclosure at this point in the process is not warranted.

Patient complaints are, at this point, just uninvestigated allegations. They should not be subject to disclosure. I would suggest that the statutes ensure that complainants be advised of the disposition of the complaint, and perhaps provide for some review of a decision that further disciplinary proceedings are not warranted.

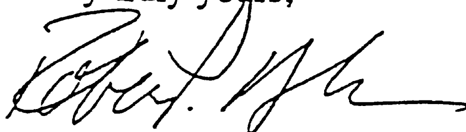
In working across the spectrum of disciplinary information listed in the notice, my assumption was that the disciplinary process for all of these regulated professions is working properly, and that public confidence is justified. If it appeared, for example, that patient complaints or the reports from health care entities were being ignored, disclosure of the more preliminary information might have to be revisited. We would be concerned at that point with the integrity of the disciplinary process, a broader matter than the competence of the individual practitioner. To enhance public confidence in the disciplinary process, legislation requiring the Department to provide the General Assembly annually a report on the disciplinary proceedings in each regulated profession might be advisable. Such a report might include, for example, the number of complaints received, the number dismissed as unfounded, and the disposition of the balance. It might describe broad classifications of complaints, and some analysis of the information presented.

You may be aware that the Joint Legislative Audit and Review Commission completed a study last year of the Virginia State Bar. A portion of that study related to the disciplinary process in the legal profession, and the report discusses some of the issues raised by your notice of public hearing. See Senate Document No. 15, 1996 Session, at pp. 35 - 62.

In summary, I suggest that the proper uniform policy would provide that final disciplinary actions be not just disclosed, but disseminated; that any matters of public record anywhere which are in the possession of any board be disclosed upon request; that public policies expressed in the Administrative Process Act and the Freedom of Information Act not be contravened at earlier stages in the disciplinary process; that complaints and reports (other than matters of public record) not be disclosed except in the course of the disciplinary process; and that a complainant be advised of the disposition of the complaint.

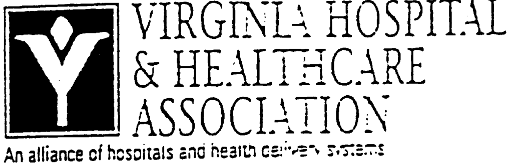
We appreciate the opportunity to offer our views on this important subject.

Very truly yours,



Robert P. Kyle
Vice President

OFFICE JUN



4200 INNSLAKE DRIVE, GLEN ALLEN, VIRGINIA 23060
P.O. BOX 31394, RICHMOND, VIRGINIA 23294
(804) 747-8600 FAX (804) 965-0475

June 4, 1996

John W. Hasty, Director
Department of Health Professions
6606 West Broad Street
Richmond, VA 23230

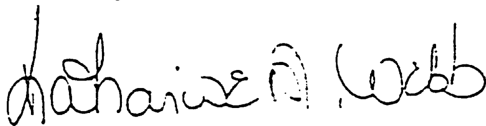
Subject: Public Hearing – Disclosure of Disciplinary Information

Dear Mr. Hasty:

The Virginia Hospital & Healthcare Association wishes to respond to the Department's and Board's notice of public hearing as part of the Board's review of the disclosure of disciplinary information in the possession of health regulatory boards. We are unable to attend the hearings but would appreciate consideration of the attached written comments during the Board's review.

We appreciate this opportunity to comment. Please contact us if you need additional information or assistance.

Sincerely,



Katharine M. Webb
Senior Vice President

sdh

Attachment

COMMENTS OF THE VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION ON THE DISCLOSURE OF DISCIPLINARY INFORMATION

On behalf of the approximately 100 hospitals and health systems represented by the Virginia Hospital & Healthcare Association (VHHA), we appreciate the opportunity to comment on the disclosure of disciplinary information as the Board of Health Professions reviews these issues.

Hospitals are subject to certain statutory requirements for reporting disciplinary action to health regulatory boards. Hospitals also seek information on health professionals for consideration in credentialing and hiring decisions. Hospitals' concerns about the availability of information on practitioners have arisen particularly in the context of physician conduct. Hospitals have raised questions as to the most appropriate way to share information among hospitals when a hospital knows of problematic conduct by a physician seeking hospital privileges. Difficulties are posed in sharing information because of the need to protect the statutory privilege in order to maintain an open and candid peer review process. There is also potential for lawsuits should hospitals share such information. Given these barriers, the Board of Medicine may be the most appropriate source of such information. However, no information is available if a case is not final but only under investigation. Also, reports to the Board of Medicine based on evidence indicating a reasonable probability that a physician is or may be incompetent, guilty of unprofessional conduct, or mentally or physically unable to practice safely are not subject to a reporting deadline; thus, a hospital may make inquiries to the Board for information on a practitioner before such suspicions have been reported to the Board.

Beyond these hospital-specific concerns, the VHHA has advocated in recent years for programs that will give stakeholders – consumers, providers, health care purchasers and state government policy-makers – more useful information on health care cost and quality to help them make wise health care choices. Consumers often may be unaware of the availability of basic information on the competency of providers, as indicated by the passage of HB 1134 this year. In this legislation, the General Assembly requires practitioners whose licenses are suspended or revoked by and Board of Medicine to give notice of such action to their patients, hospitals that have granted them privileges, and health plans reimbursing them for services.

Given these interests and concerns, the VHHA applauds the passage of HB 1307 in 1996, which moves the governance of these data initiatives from the Virginia

Health Services Cost Review Council into the hands of these stakeholders, represented on the Board of Virginia Health Information, Inc. (VHI) This nonprofit organization currently contracts with the VHSCRC to implement data activities and will continue to perform these services as the VHSCRC is dismantled by July 1, 1996. VHI will develop a strategic plan by October 1996 to determine what data these groups want and need and to begin planning for the assessment of quality of health care services. The Board of Health Professions may wish to consult with the VHI Board to determine together what provider disciplinary information should be available to consumers and others and to coordinate efforts toward the collection and disclosure of such information.

To assist you in your examination of policies governing disclosure of disciplinary information, we direct your attention to the attached article from the VHHA publication "Review," describing consumer research conducted by Southeastern Institute of Research (SIR), under contract with VHHA. SIR conducted statewide consumer research to determine what consumers want to know about physicians, hospitals, nursing homes and health plans and what employers want to know about health plans as they purchase health coverage for their employees. The research reveals consumers' needs for information to help them choose qualified health care providers and their uncertainty as to the most reliable sources of such information. Virginia's health professions regulatory boards and VHI both can apply these findings as they consider the specific information that consumers and other health care stakeholders want and need.

Thank you for your attention to these comments. Please contact us if we may be of assistance in your study.

APPENDIX D

INSTRUCTIONS

SURVEY ON DISCLOSURE OF DISCIPLINARY INFORMATION ON HEALTH CARE PRACTITIONERS

Contact Person: Any questions may be directed to **Barbara Peery** through the following numbers:

Phone: (804) 353-2543
FAX: (804) 353-0127
e-mail: VTQS56A@PRODIGY.COM

1) The survey is designed to accommodate known variation in policy and procedure among states. In addition, most questions provide space for additional comments. (Additional sheets may be attached if you believe it is necessary.)

Please feel free to provide any additional information that you believe will be useful in providing clear understanding of your specific situation.

2) A list of terms is provided. This is necessary in order to avoid variable interpretation in situation where such variation is inherent. Please use the definitions provided in responding to questions.

3) The survey is designed to require minimal time for completion (perhaps 15 to 20 minutes.)

4) Once the survey is completed, please return it in the stamped envelope that is provided.

YOUR PARTICIPATION IS GREATLY APPRECIATED. A SUMMARY OF RESULTS WILL BE MADE AVAILABLE.

PLEASE RETURN THE COMPLETED SURVEY BY JUNE 14, 1996.

SURVEY ON DISCLOSURE OF DISCIPLINARY INFORMATION ON HEALTH CARE PRACTITIONERS

Department of Health Professions
Commonwealth of Virginia

It is recognized that procedures and practices differ among states and across boards within states with regard to consumer complaint handling and public disclosure of information in cases of misconduct or alleged misconduct on the part of health care practitioners.

This study addresses issues of: 1) availability and nature of information disclosed to consumers (i.e. individuals, employers, policy makers etc.), 2) uniformity of disclosure policy across states and across boards, 3) frequency and purpose of consumer inquiry and 4) current trends in policies with regard to complaint handling and information disclosure.

The survey is designed to obtain relevant study information from selected states and professional boards.

Questions are based, in part, on general information that is known from prior discussion with participants.

Upon completion of the study, summary information will be available.

Terminology

1) Complaints = reports made by consumers or others such as health care facility administrators to a department of health professions or board which bring into question the professional conduct of a health care practitioner and which may or not be investigated

2) Cases/Pending Cases = those complaints which will be investigated, are under investigation or which have been investigated but which have not yet been disposed of through the disciplinary function (i.e. Evidence is sufficient to warrant investigation and/or that investigation is underway or investigation has been completed and the disciplinary question has not been resolved.)

3) Disciplinary Actions/Sanctions = those cases which have been investigated and which have resulted in disciplinary action against a health care practitioner (eg. reprimand, probation or revocation or license etc.)

4) Closed Cases = investigated cases which did not result in discipline and which will not involve further action

5) Disciplinary Information = any adverse information regarding a licensee in the custody of the agency including allegations, citizen complaints, malpractice reports, investigations, notices of hearings, orders of health regulatory boards and any other similar information

6) Consumer = any member of the public including, but not limited to, patients, employers, administrators of managed care programs, policy makers, and others

PARTICIPANT INFORMATION

State ______________________________

Board ______________________________

Number of Licensees ______________________

Person completing the survey ______________________________

Phone Number ______________________

I. Disclosure of Disciplinary Information

1) Is disciplinary information of any type disseminated to the public by the board or another state entity as a matter of policy?

_______ yes _______ no

2) If you responded "yes" to the previous question, please indicate the type of disciplinary information that is publicly disseminated as matter of policy.

Comments:

3) If known, how many inquiries/requests for disciplinary information does your board receive yearly?

____

PLEASE PLACE A CHECK TO THE LEFT OF THE STATEMENT OR STATEMENTS WHICH APPLY TO YOUR AGENCY/BOARD. IF ADDITIONAL, RELATED INFORMATION IS REQUESTED OR IF YOU BELIEVE ADDITIONAL EXPLANATION IS NECESSARY, PLEASE PROVIDE COMMENT.

4) Disclosure of disciplinary information is: (Please check one.)

_______ a) directly controlled by state legislation.
(i.e. There is state legislation which
directly specifies limits on disclosure?)

_______ b) determined through board/agency policy which is
based on broad statutory mandates.

_______ c) Other; Please explain briefly.

Explanation and/or additional comments:

5) Inquiries/requests for disciplinary information are typically made by: (Please check all that apply.)

_______ a) individual consumers of health care services.

_______ b) employers (i.e. employers who may have interest related to employee benefits packages).

_______ c) administrators of managed care or other similar programs.

_______ d) policy makers.

_______ e) Other. Please explain.

Explanation and/or additional comments:

6) The Board or another state agency actively and formally provides education and/or information to the general public on:
(Please check all that apply.)

_______ a) the right to access disciplinary information on health care practitioners.

_______ b) the means through which disciplinary information may be accessed (i.e. phone numbers, written procedures etc.).

_______ c) the type of information that is available to the public.

_______ d) Consumer education and/or information is not actively and formally provided.

If you checked either "a", "b" and/or "c" on this question, please explain briefly how and by whom this information is disseminated.

Explanation and/or additional comments:

7) When a consumer wishes to access disciplinary information from the board on a health care practitioner, he/she is: (Please check one.)

_______ a) able to obtain information by making a phone call and speaking with a board representative.

_______ b) able to access information through an automated phone system.

_______ c) required to write a letter requesting such information.

_______ d) required to complete a specific form designed for such inquiries.

_______ e) Other; Please explain briefly.

Explanation and/or additional comments:

8) (NOTE: Please review the terms provided on page one if necessary.) When a consumer requests information on a health care practitioner, he/she is provided access to information on: (Check all that apply.)

_______ a) disciplinary actions/sanctions taken.

_______ b) cases pending cases.

_______ c) closed cases.

_______ d) all complaints.

_______ e) None; Information is not provided.

Explanation and/or additional comments:

9) Certain information that is obtained during investigations is legally protected from public access (eg. names of patients in patient records) by statutes which cover a wide range of situations. Which of the following best describes the practices of your board with regard to information that is not protected in this way? (Please select one.)

_______ a) All information is made available to the public upon request.

_______ b) All such information is technically available to the public. However, discretion is exercised on a case-by-case basis.

_______ c) Information is further limited by board policy and no further discretion is made.

_______ d) Information is further limited by state statute which specifically addresses disclosure of such information and which applies to the board specifically.

_______ e) Other; Please explain.

Explanation and/or additional comments:

10) If you responded to the previous question by checking either "b", "c", "d" or "e", please provide a brief explanation of the degree of limitation by indicating the nature and type of information that is disclosed.

11) Are there any recent changes in the board's policy and/or procedures with regard to disclosure of disciplinary information? If yes, please provide a brief explanation.

II. Consumer Representation on Boards

1) The board consists of ______________ members. Of this number, ______________ are consumer representatives.

2) Through what action (eg. appointment by Governor or board selection) are consumer representatives place on the board? .

3) Please explain any restrictions that are placed on consumer representatives.

III. Complaint Process

PLEASE PLACE A CHECK TO THE LEFT OF THE STATEMENT OR STATEMENTS WHICH APPLY TO YOUR AGENCY/BOARD. IF ADDITIONAL, RELATED INFORMATION IS REQUESTED OR IF YOU BELIEVE ADDITIONAL EXPLANATION IS NECESSARY, PLEASE PROVIDE COMMENT.

1) If one wishes to make a complaint or report regarding the conduct of a health care practitioner he/she: (Please check one.)

_______ a) is required to do so in writing either through a letter or by completing a specific form.
_______ b) may do so by making a phone call.
_______ c) Other; Please explain.

Explanation and/or additional comments:

2) Complaints made regarding the conduct of a health care practitioner: (Please check one.)

_______ a) are always investigated as a matter of board policy.
_______ b) are evaluated by an intake officer or other individual who is assigned only to your board and who determines whether the complaint and evidence warrant investigation.
_______ c) are evaluated by an intake officer or other individual who is assigned to more than one board and who determines whether the complaint and evidence warrant investigation.
_______ e) Other; Please explain.

Explanation and/or additional comments:

3) An investigation may be initiated as a result of: (Please check all that apply.)

_____ a) an anonymous call or letter.

_____ b) information obtained from a newspaper or other news media.

_____ c) inspections.

_____ d) Other; Please explain.

Explanation and/or additional comments:

4) During investigations of complaints, the complainant is:

_______ a) kept aware of the status of the investigation throughout the period of investigation.

_______ b) at least notified of evidentiary hearings (or the equivalent) related to an investigation.

_______ c) formally apprised of the outcome (i.e. the disposal of the case whether or not disciplinary action is taken).

_______ d) provided a means of appeal in cases which do not result in disciplinary action.

_______ e) Other; Please explain.

Explanation and/or additional comments:

THANK YOU!